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# VITAMINS IN CANNED FOODS

## IV. VITAMIN $B_1$

• The story of vitamin $B_1$ is quite long and involved. Properly, it has been fully covered at some length in authoritative dissertations on the vitamins (1).

The original vitamin B of Eijkman and of Funk, while definitely possessed of antineuritic potency, is now known to be of a complex nature. Between 1919 and 1926, the vitamin B complex was resolved into vitamins B ($B_1$) and G ($B_2$). Subsequent work has indicated the existence of other vitamins in the complex, whose chemical natures or relations to human nutrition are not as yet clearly understood.

As a direct result of many researches on vitamin concentrates, the chemical identity of the crystalline antineuritic factor has recently been described as a derivative of 6-aminopyrimidine (2).

It has been known for many years that vitamin $B_1$ may be destroyed by heat. In the canning procedure, a number of heat treatments of food may be involved, especially in the thermal "processing" of the product to insure its preservation. In the "process", many foods are subjected to a heat treatment after sealing in the can, to destroy spoilage organisms which may be present on the raw material. In other cases, the food is filled into the cans at a sufficiently high temperature to obtain the same result. Therefore, the question of the effect of the canning procedures on vitamin $B_1$ frequently arises.

The times and temperatures necessary for the processing of canned foods are governed by a number of factors, important among them being the pH of the food itself. Highly acid foods require only short heat processes at the temperature of hot or boiling water to destroy spoilage organisms. The so-called "non-acid" or "semi-acid" products require higher temperatures — usually 240° F. (116° C.).

As might be expected, acid foods have been found to suffer only a slight loss of vitamin B during canning (3).

The degree of retention of vitamin $B_1$ in the non-acid foods is not as high as in the acid foods. (4).

This is partly due to the heat treatments accorded them and possibly also to their low acidity, since the vitamin is more stable in acid media.

The facts in the case may be summarized briefly by the statement that commercially canned foods may be depended upon to supply vitamin B to extents consistent with the amounts of the vitamin originally present in the raw materials from which they were prepared. Because of their widespread use, canned foods contribute a notable amount of vitamin $B_1$ to the American dietary.



(1) Vitamins: A Survey of Present Knowledge Medical Research Council, Special Report Series, No. 167, 1932. His Majesty's Stationery Office, London

The Vitamins H. C. Sherman and S. L. Smith 1931 Am. Chem. Soc. Monograph, 2nd Edition

(2) 1935. J. Amer. Chem. Soc. *57*, 1751

(3) 1932. Ind. Eng. Chem. *24*, 457

(4) 1932. J. Nutrition *5*, 307

# For Children's Colds

THE ease of application which makes Benzedrine Inhaler so useful with adults is even more important in treating the congestion occurring in children's head colds. The vapor form—in addition to its greater effectiveness — overcomes the strenuous objections which children show to liquid inhalants as applied by drops, tampons or sprays.

Furthermore, the simplicity of Benzedrine Inhaler makes it especially suitable for pediatric use; it has been shown to have no deleterious effect even on the delicate cilia of the nose. Nor is there any oil to be aspirated and become a potential source of later trouble by accumulating in the lungs (Graef: Am. J. of Path., Vol. xi. No. 5, Sept., 1935).

Secondary reactions are "so infrequent and so mild as to be virtually negligible" (Scarano: Med. Record; Dec. 5, 1934), and even in very young children, overstimulation or other undesirable reactions do not occur with the proper dosage.

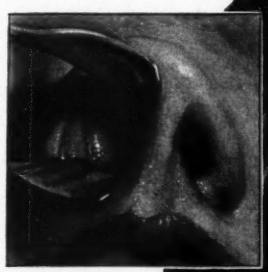

**FIG. 1.** J.M.C. White, female, age 4. June 5, 1936. Acute rhinitis.
11:40 A.M. Two inhalations of Benzedrine inhaler.

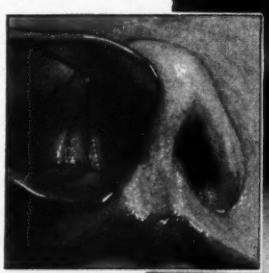

**FIG. 2.** 11:50 A.M. Maximum shrinkage evident.



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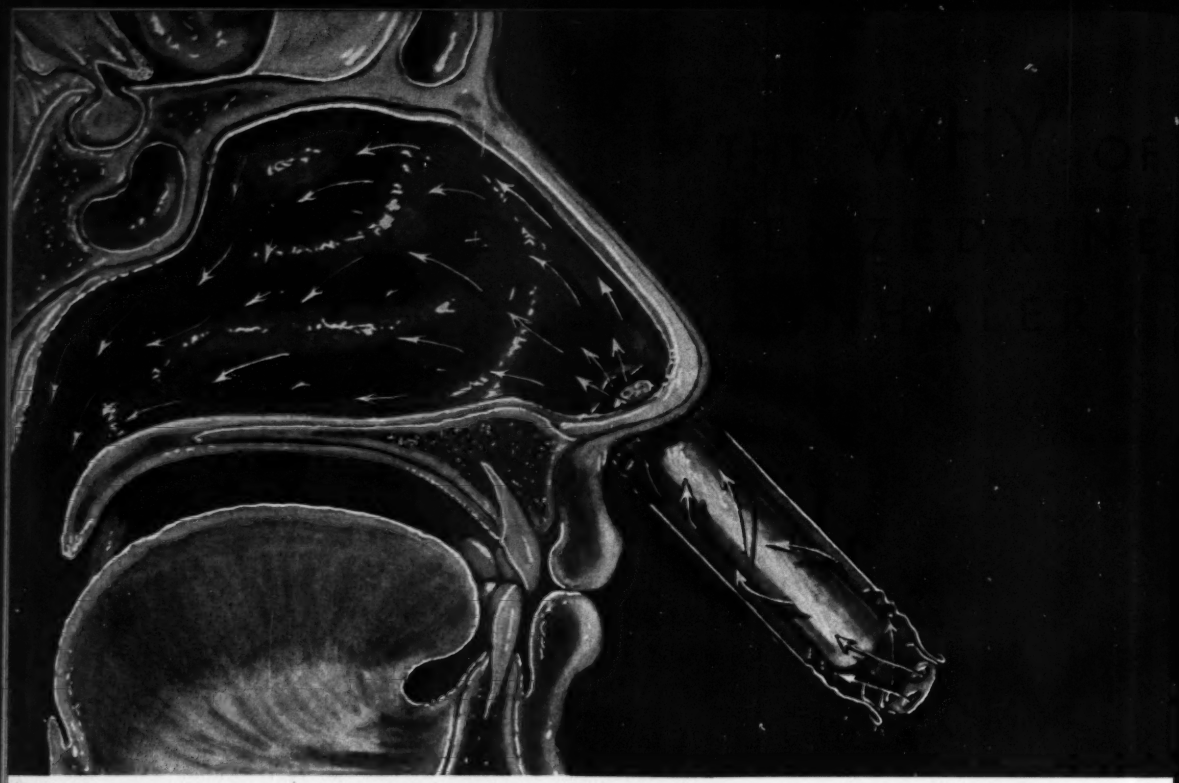
## BENZEDRINE INHALER

A Volatile Vasoconstrictor

SMITH, KLINE & FRENCH LABORATORIES, PHILADELPHIA, PA.

EST. SKF 1841



- The structure of the rhinological tract is so complicated that, when congestion is present, the whole of the affected area cannot easily be reached by a liquid vasoconstrictor.
- On the other hand a volatile vasoconstrictor diffuses throughout the entire nasal cavity. Benzedrine* is a vasoconstrictor combining VOLATILITY with a POTENCY greater than that of ephedrine.
- To present these two properties of Benzedrine in the simplest and most convenient manner, the inhaler form was adopted—an aluminum tube with gas-tight screw caps, containing a cotton roll impregnated with Benzedrine.
- Thus, though the word "inhaler" may suggest the outmoded aromatic inhalers of the past, actually this presentation of Benzedrine is logically dictated by the properties of the drug itself.
- And Benzedrine Inhaler—effective, convenient and inexpensive—marks a distinct therapeutic advance in the symptomatic treatment of head colds, sinusitis, vasomotor rhinitis, hay fever and nasal congestion generally.

# BENZEDRINE INHALER

Each tube is packed with benzyl methyl carbinamine, .325 gm. oil of lavender, .097 gm.; menthol, .032 gm.

*Trade Mark Reg. U. S. & Can. Pat. Offs.

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## HISTORY OF MEDICINE IN DELAWARE*


JOSEPH B. WAPLES, M. D.
Georgetown, Del.


I never knew how sadly the early history of medicine in Delaware had been neglected until I started this paper. I suppose the reason was that most of the medical aid was given by old women and by men who had never studied medicine but resorted to those home remedies that we still find traces of in the older country families. Yet there were a few doctors whom we find mentioned among the early settlers.

Dr. Tyman Stidham landed at New Castle, then called Fort Cassimer, May 21, 1654, and later moved to Fort Christina, now within the limits of Wilmington. He died in 1686. Dr. John Rhodes was among the earlier settlers at Lewes, but was killed by the Indians within the first year. Then Dr. John Jardine settled in Kent County in 1675, and Dr. Charles Haynes landed at Lewes.

As there were, of course, no medical schools in this country these good pioneer physicians acted as preceptors to many and by so doing perpetuated the medical treatment in this state for many years to follow. Among the next group of physicians were Dr. Moses Marshall, 1758-1813 and Dr. William Baldwin, 1779-1819 and Dr. William Darlington. These doctors lived at a time we might call the botanical era, as they were botanists of some note and busily sought plants, experimented with them and interchanged their findings with the physicians across the sea. These experiments and medical claims for certain plants brought about a bloodless war between those claiming and others disclaiming the therapeutic action and properties of many of the extracts.

It was about this period that the physicians began to realize how necessary it was for them to get together at least once a year, as there were no journals, to discuss the self-acquired knowledge obtained by the experimentation and the practice of the different doctors.

On February 3, 1789, an act incorporating the physicians of Delaware was passed by the General Assembly. A copy of the act appeared in the Delaware Gazette in April naming twenty-seven physicians, all doctors in the state at that time, as corporators. These physicians met in Dover on the following May 12, just 12 days after the inauguration of Washington, and organized our present State Society, the third of its kind in America, by electing Dr. James Tilton, president; Dr. Jonas Preston, vice-president; Dr. Edward Miller, secretary; and Dr. James Sykes, treasurer.

These first members were men with souls and realized the real benefits of meeting with their colleagues, as was shown by their interest in forming a society at a time when the means of transportation was by horseback over very bad roads. I wonder what our attendance would be today were we to have that mode of travel.

I would be going amiss were I not to mention some of our first members and their deeds. Our first president, Dr. James Tilton, was born in Kent County in 1745 and was educated at Nottingham Academy in Maryland. He became interested in medicine, and as his widowed mother was financially unable to send him to the old country he apprenticed himself to Dr. Charles Ridgely of Dover. A few weeks or months later there was started a medical school at the college of Philadelphia, now the University of Pennsylvania, with Dr. William Shippen as professor of anatomy and surgery, and Dr. John Morgan as professor

*Presidential address, read before the Medical Society of Delaware, Rehoboth, October 13, 1936.

of medicine. Dr. Tilton, after serving a short time with Dr. Ridgely, entered the new medical college and graduated with the first medical graduating class and was awarded the degree of Bachelor of Physics. He then returned to Dover and began the practice of medicine but continued to study until in 1771 when he went back to Philadelphia to receive the degree of Doctor of Physics.

At the outbreak of the Revolutionary War he joined the Army with the rank of lieutenant of infantry, and soon was made surgeon. In this position he saw men die by hundreds, in overcrowded and poorly ventilated hospitals, in fact more died with disease than bullets.

He reorganized the hospitals and built log cabins and tents, well ventilated and clean, and placed six sick men in each. This soon corrected the physical condition of the sick and saved the Army from destruction by disease. At the end of the war Dr. Tilton returned to Dover for awhile but his failing health forced him to move to Wilmington in retirement until the War of 1812, when he was called to be placed as the first Surgeon General of the Army. In 1814 he published in general orders "Regulations of the Medical Department." In 1815 he returned to Wilmington hampered by a malignant tumor which made it necessary to amputate his leg at about the age of 70. He underwent the excruciating pain of amputation, as there were no anesthetics, and recovered. The remainder of his life was passed in retirement and he died May 14, 1822.

Dr. Edward Miller, our first secretary, was born near Dover in 1760. He was educated at Newark Academy, now the University of Delaware. In 1796 he moved to New York, and with the Doctors Mitchell and Elihu Smith published the first medical journal, "The Medical Repository." Dr. Miller is best remembered for advocating the use of Peruvian bark in yellow fever and malaria, as well as the drinking of plenty of water in fever cases. He died in 1812.

I have already given much time to these two great men and can only mention a few of the other honored physicians: Dr. Jacob Jones, better known as Commodore Jones, commander of the Wasp; Dr. Macdonough, father of Commodore Macdonough; Dr. Charles Ridgely, outstanding physician of Dover; Dr. Joshua Clayton, twice Governor of the state and once U. S. Senator; Dr. Joseph Hall, prominent physician of Lewes, born 1742; Dr. Nicholas Way, of Wilmington, born 1750; Dr. Henry F. Askew, born 1805, leader of his profession in Delaware, was president of the American Medical Association, and died 1876; Dr. James B. Lofland, born 1793, located in Milford, died in 1852; Dr. Robert R. Porter of Wilmington, born 1811, and died 1876; Dr. Lewis P. Bush, born in Wilmington 1812; Dr. William H. Wolf of Milton, preceptor to many and the first president of the Sussex County Medical Society; Dr. William Marshall, grandfather of Doctors Williams and Samuel Marshall of Milford, was the first secretary to the Sussex County Medical Society; Dr. Hiram R. Burton, of Lewes, served in Congress; Dr. Willard Springer, founder and first president of the New Castle County Medical Society; Dr. Peter W. Tomlinson of Wilmington. Many others should be mentioned if time permitted. We, most certainly, must look back on these men with great admiration when we think of the period in which they lived. These early physicians not only mixed their compounds but extracted the ingredients from herbs. They also made many surgical instruments to meet their immediate demands.

In my childhood I remember so well visiting homes with my father and having him call for a knife and plate for mixing his medicines and making pills. These men, I dare say, were much better versed in materia medica than we are today. Think, too, of their means of travel—horseback or horse and buggy over bad roads—in comparison with our automobiles and hard surfaced roads. I, like many here today, experienced country practice before automobiles came into general use and can appreciate my predecessors in general practice.

At the Centennial meeting of our State Society in 1889, it was suggested by the president, Dr. W. T. Skinner, that each county have a society and hold monthly meetings. Antedating this by 26 years, the Sussex County physicians met in Georgetown, December 15, 1863 and organized the Sussex County

Medical Society by electing Dr. William H. Wolf, of Milton, president and Dr. William Marshall, secretary.

The New Castle County Medical Society was organized in 1901. Dr. Willard Springer was elected president, and Dr. Joseph W. Bastian, secretary.

I was unable to find the date of the beginning of the Kent County Medical Society. Nevertheless, all three are active.

The history of our State Society should be a real stimulus to all of us to put our shoulders to the wheel, and to keep our Society as good as it has been or even better by showing more interest and better attendance.

## WHY AM I A DOCTOR?*

FLOYD S. WINSLOW, M. D.**
Rochester, N. Y.

Why am I a doctor? Did you ever ask yourself this question? Perhaps it will not be amiss, once in a while, if we examine this basic question. It will be good for us to indulge in what might be called a "periodic self-examination."

Certainly we are not doctors because of the money that is in it. Generally speaking, our companions of early years who selected business pursuits have outstripped us in gathering together the collection of objects which represents monetary success. Why did we go into medicine? Why do we stay in medicine? Why do we live for, fight for, and sometimes die for medicine?

Glory? Where is the romance in our pursuit, for those who follow it? It is said that every ship is a romantic object but the one we are sailing in, and it may also be said that medicine has romance for those who do not practice it. We work in the quiet of the sick room, or the hospital, we walk daily with troubled humanity. Our satisfaction can only derive from the knowledge that we have performed our obligation to heal the sick, in this way paying the debt we owe for the accumulated knowledge and experience of the ages which has been made available to us.

Perhaps this feeling of responsibility is an ideal which we do not always reach, but is it any less our ideal? We can say, without fear of contradiction, that the great majority of doctors are imbued with the purpose to discharge this obligation. And I think the time has come when the public should know, should be definitely told, that the most important thing it should inquire about, when selecting a doctor, is whether he is genuinely interested in his calling, loves his profession, and is not only intent to attain ability as a physician, but feels a responsibility to advance the capacities of the medical profession as a whole. This is, as you know, the main object of medical societies. The man who has such a goal as this in mind as a destiny, is a man who can be fully trusted with the lives of men and women and children.

I will go even further than this and say that I think I stand here facing a group of men who have stood the test of this criterion. In other words, this test of character. You have joined your county medical society. You consider that when you were given the right to practice medicine, you assumed an obligation to do your part to see that medicine, as a profession, preserved its integrity. Now gentlemen, the only way integrity can be attained or retained, is to work for it. When you join your local medical society you work for the integrity of yourself and the group. You render yourself open to the criticism of your peers. You say, in effect, "I intend to behave myself, to put the interest of my patient above my own, to observe all the other provisions of the oath of Hippocrates, in letter and in spirit. And not only do I intend to do this, but by joining the county medical society *I have to do it*—I lay myself open to penalties if I do not."

I think the public should be told that a doctor who is a member of his county medical society is a better doctor on this account. I think a patient should ask his doctor, if he is not a member of the medical society, why he is not a member. It is possible, of course, that a physician may be of the highest rank, and not be a member; there is nothing compulsory about it, but as I go over in my mind the names of the physicians who I find have lived so that their excellence is beyond possible question, I do not think I can name one who is not a member of his county medical society.

*Talk delivered at meeting of the Rochester, N. Y., Eighth District Branch of the Medical Society of the State of New York at Buffalo, October 15, 1936.

**President, Medical Society of the State of New York.

Now if our loyalty to our profession is merely another form of loyalty to society—to mankind—a point comes up which I wish now to mention. The world today is facing deep and important problems. Confusion abides in the minds of men. Quacks are abroad plying their trade in the realm of economics and sociology as well as in that of medicine. Large groups of people are assuming to know that which they do not know. They are contemptuous of the experience of the past, and of the experience of individuals, they decry special skills, they substitute rhetoric for reason. So we have another obligation, just as basic as the medical obligation, and that is a social obligation. We must reach out and interest ourselves in these questions which are quite outside medicine, but which need a generous skepticism to counteract what often seems to be a pathological optimism. We have not repaid our debt to society when we merely heal the sick. In some respects, the well need healing, too. That is to say, if we are not to have all our values, all our superiorities broken down. "One man," Dr. Dooley said, "is not only as good as another, but a damned sight better." There are no experts left. There are only simplifiers. And what are we doing about it?

This is not a matter of partisan party lines: the same kind of thinking is to be found everywhere. The public is coming to believe that it is capable of exercising its opinion, its judgment, on difficult technical problems, with no knowledge, no experience. Further than this, it expresses that opinion in response to a catch-word. It does not even make the effort to think a problem through on a rational basis, using the information, however inadequate, which it has in its possession. These are symptoms of grave danger. Sooner than we think, we may see the complete triumph of mediocrity. And there is only one way in which we can make effectual remonstrance, and that is at the polls on election day. Yet I am told by those who have made inquiry that the proportion of doctors who vote is only one in three. Need I say that this is a disgraceful record? Need I urge you to consider its significance deeply, when so many public policies are formulating which may advance or retard the healing art? You know what various candidates stand for, and in general, if not specifically, what type of legislation may be expected of them. Your knowledge, your judgment, is ineffectual unless you vote.

After you have asked yourself why you are a doctor, ask yourself another question, a larger question. Are you a citizen, in fact rather than in name, if you fail to exercise the obligations of a citizen in exchange for its advantages? If we work in our own societies to preserve the integrity of medicine but fail in the larger society of American affairs to preserve the integrity of our civilization, efforts on the one part may easily be frustrated by inaction on the other.

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## PSYCHIATRIC THOUGHTS

M. A. TARUMIANZ, M. D.*
Farnhurst, Del.

The practice of medicine involves more than the diagnosis and treatment of a disease entity or of a complication of diseases of an organic nature, for every physical case is also a mental case, the type and intensity of the mental symptoms depending upon the temperament of the patient.

Illness which results in a change in the well-being of an individual, as well as, frequently, in the environment may also cause a loss, in certain cases, of the feeling of security which is so essential to the welfare of an individual in avoiding abnormal mental tension. In others, the added attention and solicitation produces within the individual a sense of being protected, resulting in a tendency to return to an infantile level of dependency, thus, in certain patients, producing a desire to prolong the illness which is making it unnecessary for him to face adult life problems. This may become extremely marked where there is an over-solicitation on the part of relatives and attendants. In certain unstable individuals there may now well result the chronic invalidism of a neurosis, the patient by this means unconsciously attempting to escape unpleasant problems of adult life.

Not only do we have affective or purely psychogenic changes, but in many instances also organic illnesses, due to toxic reactions on the brain of the abnormal products of the dis-

*Superintendent, Delaware State Hospital.

ease; or an indirect reaction due to changes in activity of the endocrines. In considering these factors it can readily be seen that mental changes, true at times very slight, must occur in nearly all cases of physical illness. These mental variations must be treated with the physical ailment, not only to relieve the present mental instability but to prevent further and more chronic psychogenic reactions in more or less constantly unstable individuals, resulting from the false environment during invalidism. It is therefore important that every physician, whether in general practice or in a specialty, should understand the fundamental aspect of temperament and personality, to obtain the most satisfactory results of the treatment which they prescribe.

Temperament is that inherent part of the personality over which the individual has no control. Its activities may be directed, but that which individualizes humanity is always present and cannot be changed. For many years four different types of temperament have been described, a classification which still may well be used; viz: sanguine, melancholic, choleric, and phlegmatic. Kretschmer later speaks of two main temperaments, the cyclothymic and the schizothymic, which compare to some degree with the extroverted and introverted personality types of Jung. These manifestations of temperament may be caused directly by heredity or race, or may be due to characteristic endocrine functioning. If temperament is caused either directly or indirectly by individual differences of endocrine functioning it may be necessary that we change our present concepts, for with such a purely physiological basis it may be possible for science to change the temperament of an individual at will. This, however, seems the mere possibility of a rather distant future, and if the possibility were to become a fact it is doubtful if changing the temperament would be a wise procedure. Civilization has "de-individualized" humanity enough, at least superficially, so that it hardly seems necessary for medicine to enter the field, except in such cases where the physical well being of the individual is at stake.

In understanding the individual as a whole an account must be taken of character. Character connotes the presence or absence of will. The ideal or philosophy of life which each individual possesses either consciously or unconsciously undoubtedly plays an important part in the development of character. These ideals, or religions as they may well be called, are based on environment and education (really a phase of environment), plus the inherent intellectual capacity of the individual which is used in formulating these philosophies from past experience and reading. In the intelligent person it may become something tangible, whether social or anti-social. In the non-intelligent person or unstable individual it may become a behavior pattern which may seem almost inexplicable. With the establishment of these ideals, whether good or bad, which, when accepted by the individual, become a definite part of him, there is a desire for the person to follow them through to obtain mental rest, since a life lived contrary to ideals is one of dissatisfaction. The ability to follow these ideals through adversity determines the strength or weakness of the character. Character has usually been considered as rather a positive trait, being usually described as either good or bad, or we may say that a person has much character or none at all. There are, however, gradations of character as in all other human traits, the amount which the person has at his disposal being determined by the degree of adversity towards his ideal which he must face. In using the term ideal we are not assuming that it must necessarily be social in nature. Thus the criminal may have a strong character if his ideal is one of self power without regard for the rights to others. In fact, the fullfilment of his ideal requires often much more force to carry out than it does in one whose ideals take into consideration the laws and rights of others. So a person may have distinctly asocial ideals, but because of weakness of character be merely a grumbler, since he is unable to face the criticism of society or the punishment of the law. Character is far reaching in the effect, if of strength, since it hews its way through life either to the detriment or good of the rest of humanity. Temperament is felt only by close associates and makes an individual agreeable or disagreeable to live with. Temperament becomes non-important after the death of an individual, but character may become a vital thing casting its

influence through centuries of history. The German ideal that temperament is based entirely on the affective side of man while character is based on the volitional aspect accounts to a great extent for the general usage of these terms. The psychoanalytical concept implies that character is not volitional but is based on heredity and environment over which the individual has no control. Wundt says that character "is a disposition of the will." Mumann says "it is the power to keep the selected motive dominant throughout life." Character and ideals, as stated before, must go hand in hand, since a man's ideals will determine his character. A man of strong character will not deviate in his actions even if these actions may cause him almost insurmountable difficulties.

The determination may not always be admirable. Yet we must consider that a single ideal need not necessarily be carried throughout life, since there may be some change in the motive due to the experiences through which an individual passes. These experiences usually occur in the earlier years when the individual is more pliable and when habits of living are still easily changed.

Personality may be considered as the combination of the character and temperament. Although much has been written about the personality, progress has been slow. Galen and Hippocrates believed that individual characteristics were based on physiological process, a concept which is still being considered by contemporary psychiatry. While the endocrine theory is now held, they discussed the various humors. Even today we use the terms such as "galling" and "splenic" as descriptive terms of personality. When we consider the change that occurs in an individual during the process of certain diseases it is impossible to eliminate certain physiological conditions as the basis of certain psychological changes noted. This, of course, is most markedly noted in the diseases of the endocrines, but yet rather definite and characteristic changes are seen in certain other chronic diseases, such as those of the gall bladder, the stomach, and in tuberculosis. We are all familiar with the dyspeptic outlook on life.

Of great importance, due to the psychoanalytical school, has been the awakening of interest in the minds of professoinal people to the importance of mental attitudes towards physical and psychological adjustments. As in all newer theories, various schools have arisen and at times some confusion exists, but in many points there is agreement. We will take time here for only a brief discussion of the three main schools. The teaching of Freud aroused not only the professional but the lay mind and was doomed to fall into a certain disrepute because of the almost sensational publicity which it evoked. Through his work we are told that personality traits are connected with the libido and are altered through conscious or unconscious trauma to this impulse. Symbols, acceptable distortions of non-acceptable impulses, appeared in various unconscious mannerisms, or in dreams, and early the interpretation of dreams was a prominent technic in therapy. However, so many traits were held to be due to the same etiological factor and so little loophole was left for error that in spite of the knowledge which we have obtained it would seem that the inexactness of the teaching keeps it from being scientific.

Jung, although psychoanalytical in his tastes, seems to feel that self-preservation, closely linked with fear, has a great deal more to do with personality development than the libido. The extroverted and introverted types, as abnormal manifestations, are the reactions of the individual to this instinct. Whether the individual reacts in one way or another to the desire for preservation of self may be blamed on heredity, environment, or endocrinology.

The third school of psychoanalysis is that of Adler. He deviates from the other schools by his contention that personality traits and character are based on a "will to power." Organic inferiority in the normal man often results in a striving to overcome the handicap, in an attempt for establishment in the field in which the inferiority exists.

The premises differ as to which of the three desires or instincts is the one which plays a prominent role in determining what the reaction of an individual will be to certain situations as they arise. Why one process should be of greater power than another does not seem to have been clearly demonstrated. It would seem entirely within reason that the

force of these various inherent drives vary with different individuals, probably through hereditary measures either on a racial or physiological basis.

However, Adler's school more so than all others, yet in agreement with all, has brought forth a concept which can readily be demonstrated, and that is the compensatory mechanism. Any student of human nature would be able to demonstrate this many times daily.

We all realize that the contradictory behavior of most individuals can be based on a compensatory reaction. The inherent cruelty of some people shows itself in an over-solicitation, a domineerance, and results in over-cordiality. There is in all people a tendency to hide their real emotional reaction and desires by overacting the opposite of it. This compensatory mechanism may take different forms in different people. It is usually evidenced only to hide such behavior which is more or less antisocial, therefore, it is not necessary for the person who is normally (or subconsciously) tender to behave cruelly to make his adjustment since the mechanism is self-preservative in the social group. Yet we do find it occurring even under such a state, namely, that a person who is overly kind to the point of harming his own personal welfare may to the public attempt to show cynicism and cruelty.

We probably have the most commonly understood types of personality in the extroverted and introverted types of humanity. These compare with Kretschmer's cyclothymic and schizothymic types. Every individual differs to a certain degree from every other in his temperament, and because of this, in his personality. Whether a person is to be extroverted, cyclothymic, or introverted, schizothmic, depends both upon inheritance and environment, with a possibility that environment plays the predominant role. It is true that there are certain cases of schizoid or extremely introverted personalities which it seems impossible to change by any means whatever, and it is also true that children, from a very young age, brought up in an orphanage, brought up under the same environmental factors, show different personality characteristics. Some at times do not react to changes in the environmental factors; however, it is also true that these cases have not been recoginzed at an early age and attitudes have become fixed to a certain extent before therapeutic treatment can be instituted. Probably the completely introverted or completely extroverted personality offers extreme difficulty in therapy if we wish to change them. The average individual has characteristics of both in that he is self-sufficient when left alone, but cannot enjoy the group and talk freely without embarrassment. Whether a person is introverted or extroverted, as we usually consider them, depends upon which characteristic dominates in the total personality pattern. The completely introverted or schizoid individual who wishes to be alone at all times, never enjoys companionship of others and who is completely occupied with his own thoughts and day dreams, is fairly rare. Many of this type become psychotic, others become useless individuals, hermits and vagabonds, who add nothing to the well being of the world as a whole.

The completely extroverted individual shows the same picture but in the opposite direction. He is unable to be by himself a moment without extreme discomfort. His attention is so quickly distracted from one thing to another that he is unable to apply himself to any one subject to such an extent that he can successfully fulfill a given task. Adversity is apt to throw him into an extreme degree of depression. When physically ill he will become extremely hopeless, but a slight improvement will quickly encourage him to the point where he will immediately forget about his picture of despair.

The introverted individual is inclined to be more or less apathetic against adversity and it is extremely difficult to arouse him to any interest. The introverted personality is not as apt to develop obvious compensatory difficulties. He only finds his compensation in day dreaming which has no outlet. This day dreaming in which he glorifies himself and satisfies one of the inherent drives, becomes to him more or less of a reality.

The fact that character and personality is frequently recognized by the family physician at an early age, may lead to correction of abnormalities and so prevent serious consequence in mature life.

## MENTAL HYGIENE CLINIC

The Mental Hygiene Clinic of Delaware which was established in connection with the Delaware State Hospital in August, 1929, has now found it possible to expand its activities. There are now present on its staff two full-time psychiatrists and one half-time psychiatrist, as well as one half-time neurologist. Three psychologists are present on full service. The staff calls for six social workers, four of whom are present with vacancies for two more. With this increased staff, it will be possible to carry on constructive work in the Clinic as well as in those homes where such is needed. In addition, a neuro-surgical clinic is being held monthly by Dr. Grant of Philadelphia who advises operation and treatment for those cases falling in the neuro-surgical field.

The clinic is interested in four distinct types of cases:

1. Child guidance, where the child is normal but where there is danger of the child developing certain behavior difficulties because the parents are inadequately prepared to meet problems as they arise.

2. School children who are now showing definite behavior problems of an abnormal nature, either anti-social in character or excessive withdrawal from the group. Also, such cases who are showing pre-psychotic symptoms or who present neurological conditions.

3. Adults, both those suffering from psychogenic factors as well as those with definite organic conditions of the central nervous system.

4. Institutional cases, both normal and abnormal, rendering help in the classification of mental abilities and in the preparation for community adjustment later in life.

A new building has been open for the Mental Hygiene Clinic which is separate from the State Hospital. It has a separate entrance, thus avoiding any contact with the hospital proper.

Any psychiatric or neurological case can be treated at any of the clinic centers or at the Mental Hygiene Clinic building at Farnhurst where special equipment is at hand.

Those patients who are not able to pay a private fee for operative work but who are able to pay a portion of the expense, as well as indigent cases, may be seen at the neuro-surgical clinic after having first been studied by the Mental Hygiene Clinic. Whenever possible, the actual expense for laboratory work will be charged, although the same type of service will be given those who cannot pay. If the physician would state that the fee can be paid when a case is referred to the Clinic, it would greatly facilitate the work as we have no desire to send bills to those who are in a marginal state economically.

The Clinic is interested in behavior problems, particularly in children. In those cases where indicated, intensive therapeutic work will be done to prevent adult maladjustment. To date, because of the limited staff, the Clinic has been unable to do therapeutic work in any except a few picked cases, the greater part of the work being diagnostic in character. From the time of the opening of the new clinic schedule, intensive treatment will be carried out.

In order that future maladjustment or institutionalization can be avoided, the physicians are asked to help in this work and to refer such cases as show definite deviations from the normal, or the parents of such children who are in need of child guidance information.

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## SOUTHERN MEDICAL ASSOCIATION

Thirtieth Annual Meeting, Baltimore, Maryland, Tuesday, Wednesday, Thursday and Friday, November 17-20, 1936.

Physicians from the East, white members in good standing of their state medical societies, are most cordially invited to attend the Baltimore meeting as visitors. All scientific and social activities are available to registered visitors. No registration fee.

Any physician who would like to have a complete program may secure one by writing to the Southern Medical Association, Empire Building, Birmingham, Alabama.

# EDITORIAL

**DELAWARE STATE MEDICAL JOURNAL**

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All correspondence regarding editorial matters, articles, book reviews, etc., should be addressed to the Editor. All correspondence regarding advertisements, rates, etc., should be addressed to the Business Manager.

Local news of possible interest to the medical profession, notes on removals, changes in address, births, deaths and weddings will be gratefully received.

All advertisements are received subject to the approval of the Council on Pharmacy and Chemistry of the American Medical Association.

It is suggested that wherever possible members of the State Society should patronize our advertisers in preference to others as a matter of fair reciprocity.

Subscription price: $2.00 per annum in advance. Single copies, 20 cents. Foreign countries: $2.50 per annum.

Vol. VIII October, 1936 No. 10

## The Rehoboth Sessions

The one hundred and forty-seventh annual session of the Medical Society of Delaware was held at Rehoboth on October 12th, 13th and 14th. The program upheld the traditions of our ancient and honorable Society, and was carried out without a hitch. Papers and discussions were above the average, and much interest was evinced in the scientific side of our profession.

The business of the Society was transacted by the House of Delegates with courtesy and dispatch. The main items noted were the satisfactory state of the Society's finances and the need of certain minor changes in the medical practice act, for which a special committee was appointed.

A meeting for the general public was held in the local theatre, with a creditable attendance. Dr. Hayden, representing the A. M. A. headquarters, showed a most interesting and informative motion picture of the many activities of the home office, and Dr. Speer presented a popular paper on cancer, which was well received.

The Woman's Auxiliary met on the second day and had a large and enthusiastic meeting, under the presidency of Mrs. Lawrence J. Jones.

The social features of the session were much enjoyed and earned for the Sussex County Society, as hosts, the thanks of all who attended. While the record of a few years ago, 70 per cent of our membership, was not exceeded, the attendance was quite gratifying.

The following officers and committees were chosen for 1937: Dr. Charles P. White, of Wilmington, president; Dr. Roscoe Elliott, Laurel, first vice-president; Dr. C. G. Harmonson, Smyrna, second vice-president; Dr. W. M. Speer, Wilmington, secretary; Dr. A. L. Heck, Wilmington, treasurer; Dr. William Marshall, Milford, councillor.

Committee on Public Policy and Legislation: Dr. Samuel Marshall, Milford; Dr. T. H. Davies, Wilmington, and Dr. H. M. Manning, Seaford. The president and secretary are ex-officio members.

Committee on Scientific Work: Dr. U. W. Hocker, Lewes; Dr. L. J. McCollum, Wyoming; Dr. William H. Speer, Wilmington.

Committee on Publication: Dr. W. E. Bird, Wilmington; Dr. M. A. Tarumianz, Farnhurst; Dr. W. M. Speer.

Committee on Medical Education: Dr. Roger Murray, Wilmington; Dr. Stanley Worden, Dover; Dr. E. L. Stambaugh, Lewes.

Committee on Hospitals: Dr. James Beebe, Lewes; Dr. W. E. Bird, Wilmington; Dr. Henry V. P. Wilson, Dover.

Committee on Necrology: Dr. O. V. James, Milford; Dr. J. D. Niles, Middletown; Dr. W. T. Jones, Georgetown.

Dr. Stanley Worden of Dover was elected delegate to the convention of the American Medical Association, with Dr. James Beebe of Lewes as alternate.

Wilmington was selected as the next meeting place for the Society, on the second Monday of next October.

### THE PRESIDENT AND SOCIAL SECURITY

Using the occasion of the dedication of the Jersey City Medical Center, President Franklin D. Roosevelt extended appreciation to the medical profession for its services in the depression. He said:

> **Let me with great sincerity give the praise which is due to the doctors of the nation for all that they have done during the depression, often at great sacrifice, in maintaining the standards of care for the sick and in devoting themselves without reservation to the high ideals of their profession.**

This statement has been prefaced by a recognition of the fact that the Public Works Administration had increased the capacity of American hospitals by some 50,000 beds. Moreover, the President mentioned the desire of the medical and nursing professions to do more to help families of small income in time of sickness. Particularly interesting to physicians, however, were the words of assurance in which the President intimated a desire to still certain apprehensions which have been prominent in medical discussions for many months. He continued:

> **The medical profession can rest assured that the Federal Administration contemplates no action detrimental to their interests. The action taken in the field of health as shown by the provisions of the splendid social security act recently enacted is clear.**
>
> **There are four provisions in the social security act which deal with health; and these provisions received the support of outstanding doctors during the hearings before the Congress. The American Medical Association, the American Public Health Association and the State and Territorial Health Officers Conference came out in full support of the public health provisions. The American Child Health Association and the Child Welfare League endorsed the maternal and child health provisions.**
>
> **This in itself assures that the health plans will be carried out in a manner compatible with our traditional social and political institutions. Let me make that point very clear. All states and territories are now cooperating with the public health service. All states except one are cooperating in maternal and child health service, all states but ten in service to crippled children, and all states but nine in child welfare.**
>
> **Public support is behind this program. But let me stress, in addition, that the act contains every precaution for insuring the continued support and cooperation of the medical profession.**
>
> **In the actual administration of the social security act we count on the cooperation in the future, as hitherto, of the whole of the medical profession throughout the country. The overwhelming majority of the doctors of the nation want medicine kept out of politics. On occasions in the past, attempts have been made to put medicine into politics. Such attempts have always failed and always will fail.**
>
> **Government, state and national, will call upon the doctors of the nation for their advice in the days to come.**

The meaning of these words should be clear to all who read. They would seem to signify that the voice of organized medicine has been heard and appreciated in the executive branch of our government. They conclude with a promise of consultation with expert medical advice as new problems arise in the future. The devotion of the medical profession to the public need in our years of stress surely warrants such confidence.

—Editorial, *Jour. A. M. A.*, Oct. 10, 1936.

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### ANENT THE QUALITY OF MEDICAL CARE

Professor Henry Sigerist once said that the society it serves influences the type and character of medical care that society receives. Sigerist has since become one of the proponents of socialized medicine. What he said, nevertheless, based as it was on studies of the trends in medical practice during the changing epochs of history, is essentially true.

If the strong individualists who compose our great middle class are passing, as Louis Corey believes, then this country instead of consisting mostly of individual farmers, storekeepers and manufacturers will be composed of a great army of job-holders. The liberal professions of law and medicine, too, having almost no private clientele upon which to draw—because there would be so few independent persons in the society of the allegedly ensuing epoch—will perforce have to conform to the pattern of the society about them, and they also would become part of the great job-holding public. Only in this way can one conceive that the thetic statement of Sigerist can find substantiation.

Naturally it would follow, were Corey's prediction to come true—a prediction with which we do not find ourselves fully in accord—that we would have a less vital, a less virile, and a less potent middle class. Likewise we should have medical men of less calibre and of a poorer type. The job-hunting and job-holding groups are nowhere conceded the equal of those who take life as they find it and carve out for themselves from their environment, and from the circumstances it presents, careers

and achievements and worldly goods to better their living standards.

During the various phases of historical times, if we trace the trend of youth toward occupations, we find that when interesting and adventurous careers were closed to most walks of life except in the church, brilliant youth gravitated to the church. When adventure and army life held a lure under the Napoleonic influence, the brightest and best sought a Marshal's baton in an army career. When, at the end of the nineteenth century, industrial development offered fame and fortune as rewards for initiative and courage to those who essayed those careers, intellectually adventurous youth gravitated to these fields. This period also saw the rapid and astounding developments in medicine, because here too, individualistic endeavor brought adequate rewards, and the medical career was both interesting and attractive. The same brilliant types were attracted to medicine as to the industrial fields of endeavor. In all these activities, men were their own masters. They were much encouraged but not controlled by government agencies. In education the emphasis was on the development of the individual doctor, and none on anything else. Medical schools and colleges could successfully raise their standards of requirements for admission, and of curricula. To these schools came some of the best among our youth, and the institutions of learning could exercise their power of selecting the best of these. From this the public benefited by receiving better grade in medical service.

The country's educators should ponder on the problem that will confront them if the efforts of the protagonists of compulsory health insurance have their way, and such a form of delivering medical care to our people is thoughtlessly adopted.

What type of youth would be attracted to a medical career? After a difficult medical course of four years, and the necessary preparatory one, then the arduous post-graduate internship—to be qualified for what? A job, with a fixed income, with a definite number of assigned patients who, to follow the custom set in England, are not thoroughly examined even if there were time allowed to do it; fixed hours of work, perhaps a paid vacation, and at the end—a pension. A job-holder's career! A government employee with all that this implies!

Obviously such a system will attract quite a different type of men than was drawn into the present system, men who have won high renown and have given American medicine the high place it holds today.

Will not the emphasis in medical education also have to change? Will it not be necessary to train American medical officials rather than American doctors? We see a similar change in a trend in the field of nursing. Formerly all student nurses were educated alike, now there is a distinct change toward educating nursing administrators. Those who actually handle the sick have less arduous curricula to cover. Since the financial income will be greater among the medical administrators of the system than among those of the rank and file who handle the sick, medical education will soon alter to meet the demand of those who will seek careers, not as physicians to the sick, but as a part of the controlling bureaucracy set over the physicians. The colleges will give two types of education to meet the changed conditions. Reasoned out further, it will become necessary to lower standards (as was done in Russia) to attract sufficient numbers to meet the needs of the so-called lower branches of the medical system. Lower standards, reduced entrance requirements, and a totally different type of individual will be found taking up a medical career. And all this is proposed "for the betterment of mankind!"

We, who are opposed to compulsory health insurance, call to the attention of our educators these thoughts, for we are deeply concerned with the *quality* of medical care our community will receive. For it we desire only the best quality of medical care obtainable, delivered by a man or woman of the highest type.

The medical educators of our country have here a responsibility that they must continue to carry. In the discussions of the pros and cons of compulsory health insurance, obviously it is not an economic problem nor is it wholly a sociological question. It is a problem with which the educators of our youth are also concerned. Medical education must be

planned to the end that we may maintain what we have laboriously won—a lower death rate, and a lower morbidity rate than any country where compulsory health insurance is in force, and a level of preventive medicine not equalled in any of the countries of Europe whose example we are so blithely urged to follow.

—Editorial, *N. Y. S. J. of M.*, Oct. 1, 1936.

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### SUING DOCTORS

According to Henry Morton Robinson, in *The American Mercury* for July, 1936 (The Newest Medical Racket), six times as many patients sued their doctors in 1935 as in 1921. Recent figures, he adds, indicate that in 1936 approximately one doctor in twenty will be a defendant in a malpractice suit. What is the explanation of this increment in medical litigation? Are doctors becoming less competent? Is the public demanding more proficiency in results? Or is the patient more damage-minded today, at the coercion of unscrupulous legal gentlemen?

The facts would seem to indicate that because of the trend of the times, lawyers are looking more avidly towards the medical field for exploitation. The exposure in recent years of a number of large and widespread automobile injury frame-ups has signified in a startling manner the extremes to which lawyers, patients, and even physicians are willing to go to defraud insurance companies. There is the type of legal mind that delights, for a fee, to distort facts, to stretch the imagination, and even to intimidate the physician. Hence the multitude of medicolegal cases.

Doctors who are dubious as to their position when faced with a suit should bear in mind the decision of the late Chief Justice Taft, in the famous case of Ewing vs. Goode, as quoted by Robinson:

"Before the plaintiff can recover, she must show by affirmative evidence—first, that the defendant (surgeon) was unskilled or negligent, and second, that his want of skill caused injury. The facts . . . establish neither the neglect nor the unskillfulness of the treatment, or the casual connection between it and the unfortunate event. *A physician is not a warantor of cures.* If a failure to cure were held to be evidence of neglect on the part of the physician, few would be courageous enough to practice the healing art, for they would have to assume financial liability for nearly all the ills that flesh is heir to."

Doctors, of course, are not infallible. Five to ten per cent of the malpractice cases have been decided against them. But with reasonable precautions, with proper care and judgment, and with the exercise of common sense, no doctor need fear an adverse decision in court.

—Editorial, *Med. Record*, Oct. 7, 1936.

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### LAUGHING AT PAIN

Tennyson speaks of "dull narcotics dulling pain." Physicians are well aware of this technic. But wise is the patient who can laugh at pain. He need not be a stoic, but some such philosophy as enabling him to accept affliction, not as a special curse directed towards him personally, but as an inevitable process of nature, will surely tend to mitigate his sufferings. The modern humorists are no weaklings. When the ravages of illness strike them down, they do not shed tears, but they proceed to make capital of their diseases. Many a medical and hospital bill is paid for by a sense of humor.

Mark Twain laughed off many of his afflictions. O. Henry cured his spiritual ache in a masterpiece called: *Let Me Feel Your Pulse.* Irvin Cobb set the pace for the magazine writers with his classic *Speaking of Operations.* The late Will Rogers recounted his hospital adventures in a gem of humor, *Ether and Me,* part of which, it seems, appeared as an essay on his laparotomy for gallstones, called aptly enough *A Hole in One.* Lately, the renowned Arthur "Bugs" Baer has discoursed on his medical misadventures in attempting to find relief for his gallstones (*Saturday Evening Post,* July 18, 1936:—And French-Fried Potatoes).

According to his own diagnosis, he was a victim of "newspaper stomach," a rather new nosological term, which implies a gastric result of trying to eat and think at the same time. He became an expert, horizontally speaking, on clinics, symptoms, operating tables, x-rays, fluoroscopes, and bismuth. Bismuth, he says, is the stuff you drink just before your insides light up like an electric sign

at twilight; if it ever hardens inside you they set you out in the park for a memorial statue.

You aren't sick when you call a doctor, or when he calls in another. But you know you're pretty sick when they start a duet of moose-calls and you hear the surgeons charging in the underbrush. When six arrive, that constitutes a quorum, and they elect officers. He continues with further opinions on consultations, the proper technic of whispering in front of a patient, the bedside manner of visiting a patient in the hospital, and other things that would only occur to a humorist. Of course he tells of his operations; who doesn't? He discovered that by going to bed for ten or twelve days he could recover as gradually as depositors in a closed bank. He visits his old family doctor whose office hours were from pain in the morning to groan at night. He encounters the electrocardiogram; you remove your right shoe and stocking and put your left foot in a bucket of water. Your right and left hands are placed in tubs of cold chowder, and you are then wired for sound. Your heart action is indicated by a jerky line wandering all over the map, like a goat on a hill. The log of his quest for health indicated that he left nothing untried. And of course his cure was as simple as eliminating ham and eggs and French-fried potatoes. But most important in his therapy was his ability to laugh it all off.

—Editorial, *Med. Record*, Oct. 7, 1936.

## MISCELLANEOUS

### The American Board of Internal Medicine

The American Board of Internal Medicine, incorporated February 28, 1936, completed its organization on June 15, 1936. The officers chosen were Walter L. Bierring, M. D., Des Moines, chairman; Jonathan C. Meakins, M. D., Montreal, vice-chairman; and O. H. Perry Pepper, M. D., Philadelphia, secretary-treasurer. These officers with the following six members constitute the present membership of the board; David P. Barr, M. D., St. Louis; Reginald Fitz, M. D., Boston; Ernest E. Irons, M. D., Chicago; William S. Middleton, M. D., Madison; John H. Musser, M. D., New Orleans, and G. Gill Richards, M. D., Salt Lake City.

The term of office of each member will be three years, and no member can serve more than two consecutive three-year terms.

The organization of the Board is the result of effective effort on the part of the American College of Physicians in conjunction with the Section on Practice of Medicine of the American Medical Association and these two organizations are represented in the membership of the Board on a five to four ratio respectively.

The American Board of Internal Medicine had previously received the official approval of the two bodies fostering its organization, as well as that of the Advisory Board for Medical Specialties and the Council on Medical Education and Hospitals of the American Medical Association.

The purpose of the Board will be the certification of specialists in the field of internal medicine, and the establishment of qualifications with the required examination procedure for such certification.

While the Board is at present chiefly concerned with the qualification and procedure for certification in the general field of internal medicine, it is intended to inaugurate immediately after July 1, 1937 similar qualification and procedure for additional certification in certain of the more restricted and specialized branches of internal medicine, as gastroenterology, cardiology, metabolic diseases, tuberculosis, allergic diseases, etc. Such special certification will be considered only for candidates who have passed at least the written examination required for certification in general internal medicine. The operation of such a plan will require the active participation and cooperation of recognized representatives from each of such special fields of medicine.

Each applicant for admission to the examination in internal medicine will be required to meet the following standards:

*General Qualifications*

1. Satisfactory moral and ethical standing in the profession.

2. Membership in the American Medical Association or, by courtesy, membership in such Canadian or other medical societies as are recognized for this purpose by the Council on Medical Education and Hospitals of the

American Medical Association. Except as here provided, membership in other societies will not be required.

*Professional Standing*

1. Graduation from a medical school of the United States or Canada recognized by the Council on Medical Education and Hospitals of the American Medical Association.

2. Completion of an internship of not less than one year in a hospital approved by the same council.

3. In the case of an applicant whose training has been received outside of the United States and Canada, his credentials must be satisfactory to the Advisory Board for Medical Specialties and the Council on Medical Education and Hospitals of the American Medical Association.

*Special Training*

1. Five years must elapse after completion of a year's internship in a hospital approved for interne training before the candidate is eligible for examination.

2. Three years of this period must be devoted to special training in internal medicine. This requirement should include a period of at least several months of graduate work under proper supervision in anatomy, physiology, biochemistry, pathology, bacteriology, or pharmacology, particularly as related to the practice of internal medicine.

3. A period of not less than two years of special practice in the field of internal medicine or in its more restricted and specialized branches.

A sound knowledge of physiology, biochemistry, pharmacology, anatomy, bacteriology, and pathology, in so far as they apply to disease is regarded as essential for continued progress of the individual who practices internal medicine. The mere factual knowledge of medicine and its basic sciences is not sufficient. The candidate must have had training in their use in furthering his understanding of clinical medicine. This implies practical experience under the guidance of older men who bring to their clinical problems ripe knowledge and critical judgment. Preparation to meet this requirement adequately may be even more difficult to obtain than the so-called scientific training. It may, however, be acquired in the following ways:

(a) By work in a well-organized hospital outdoor clinic conducted by competent physicians.

(b) By a prolonged period of resident hospital appointments likewise directed by skilled physicians.

(c) By a period of training in intimate association with a well-trained and critical physician who has taken the trouble to teach and guide his assistant rather than to require him only to carry out the minor drudgery of a busy practice.

4. The Board does not consider it to the best interests of internal medicine in this country that rigid rules as to where or how the training outlined above is to be obtained. The responsibility of acquiring the knowledge as best he may rests with the candidate, while the responsibility of maintaining the standard of knowledge required for certification devolves on the Board.

*Method of Examination*

The examination required of candidates for certification as specialists in internal medicine will comprise, Part I (written) and Part II (practical or clinical).

Part I—The written examination is to be held simultaneously in different sections of the United States and Canada and will include:

(a) Questions in applied physiology, physiological chemistry, pathology, pharmacology, and the cultural aspects of medicine.

(b) Questions in general internal medicine.

The first written examination will be held in December 1936, and candidates successful in this written test will be eligible for the first practical or clinical examination which will be conducted by members of the Board near the time for the annual session of the American College of Physicians at St. Louis in April 1937. The second practical examination will be held at Philadelphia near the time of the annual session of the American Medical Association in Atlantic City in June 1937.

The fee for examination is forty dollars which must accompany the application and

an additional fee of ten dollars is required when the certificate is issued.

Application blanks and further information can be obtained by addressing the office of the chairman, Walter L. Bierring, M. D., 406 Sixth Avenue, Des Moines, Iowa.

### American Board of Obstetrics and Gynecology

The next written examinations and review of case histories of Group B applicants by the American Board of Obstetrics and Gynecology will be held in the various cities in the United States and Canada on Saturday, November 7, 1936, and on Saturday, March 6, 1937.

The next general examination for all candidates (Groups A and B) will be held in Atlantic City, N. J., on June 8 and 9, 1937.

Application blanks and booklets of information may be obtained from Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh, Pennsylvania. Applications for these examinations must be filed in the Secretary's office not later than sixty days prior to the scheduled date of examination.

### Traumatic Neuroses

There is little or no therapeutic benefit in cash settlements paid to injured workmen who have traumatic neuroses, according to an investigation made recently by Carl Norcross, Ph. D., of the Rehabilitation Division of the New York State Department of Education. Results of the investigation have been published under the title "Vocational Rehabilitation and Workmen's Compensation" and the report is a follow-up study of 322 workmen's compensation cases throughout New York which were closed by a lump-sum settlement of $1000 or more.

It has been generally accepted in both medical and workmen's compensation circles throughout the country, says the report, that a cash award would help to cure a neurosis. "A careful investigation made a year or more after the settlements has convinced us that the value of a cash award is vastly overrated," writes the author. "It is the settlement of the case, the actual ending of the litigation, which is of value. Whether the final compensation award is paid in one lump or extended through a number of installments makes little difference to the claimant's condition."

The investigation disclosed that 16 per cent of the men had lost a large share of their compensation through unwise expenditures. The men who had no losses were found to have dissipated their funds much more rapidly than they would have under an installment system. Both because there was found to be a wastage of compensation funds, and because there appeared to be no therapy in the settlements, the author has recommended that lump-sum settlements be discontinued.

Dr. Norcross makes a number of recommendations for improving the handling of neurotic cases in the workmen's compensation rooms. He urges that cases be given a more prompt and careful handling. The average neurotic case is open in the workmen's compensation division for nearly three and one-half years, it is said, and much of the delay is unnecessary.

The author states that neurotic conditions grow as cases are delayed. He also points out the dangerous policy of permitting claimants to read their own medical reports, or to be present when physicians are testifying, especially in contested cases where there is a difference of opinion.

In New York a compensation case theoretically may always be reopened. The report suggests that it is a poor policy to let neurotic claimants know that when their money is spent that they may try to reopen their cases. The author believes that one of the evils of the existing New York system in non-schedule cases is that claimants must be willing to accept a lump-sum settlement. After a fair offer is made, the neurotic claimant may procrastinate indefinitely by refusing such a settlement. Thus the case is delayed, and the patient's mental condition may become worse. The remedy suggested by the report is that the referee, acting on competent medical advice, fix a fair settlement and close the case, with the award being paid in bi-weekly installments.

To overcome any prejudice the claimant may have toward the insurance company, it is suggested that the money be paid to a state administered trust fund, which already exists

in New York. The carrier could close the case on its books, and the claimant could be told his case is definitely closed but that he would get all his money, regardless of his state of health. The patient would not have to remain sick to get his award.

Provision is made for permitting the claimant to get an advance on his compensation for any necessary purpose, including rehabilitating himself on a farm or in a small business.

Copies of the report may be secured through the publisher, The Rehabilitation Clinic, 28 East 21st Street, New York City. Price one dollar.

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## Army Medical Library

*Resolution Recommending the Appropriation of Adequate Funds for the Maintenance and Growth of the Army Medical Library's Book Collection and Index-catalogue.*

The Medical Library Association, comprising two hundred of the medical libraries of the United States and Canada, assembled in its thirty-eighth annual session in St. Paul, June 22, 1936, notes with pleasure and pride the appearance of volume one of the Fourth Series of the *Index-catalogue* of the Library of the Surgeon-General's Office, United States Army (Army Medical Library). The Association records with satisfaction the abbreviations and changes in composition in this new volume effecting a saving of twenty per cent in space with accompanying reduction in costs.

After a delay of three years during which no volumes of this *Catalogue* were printed, the appearance of this first volume of the Fourth Series gives renewed assurance of the continuation of this publication, which, together with the Army Medical Library, is considered the outstanding contribution which our country and its Government have made to medical knowledge, and

WHEREAS, The value and usefulness of the *Index-catalogue* is dependent upon the completeness of the files of medical publications contained in the Library of the Surgeon-General's Office—a public, national, medical library, the greatest in the world, serving in its present form of administration with satisfaction the medical profession and the medical libraries of our country, and

WHEREAS, In recent years the annual appropriation of the Congress has been wholly inadequate to provide sufficient funds to acquire the current medical books and periodicals issued throughout the world, so that they might be available for use throughout the country and for inclusion in the *Index-catalogue.*

THEREFORE BE IT RESOLVED, That the Medical Library Association urges the Congress to appropriate annually to the Library of the Surgeon-General's Office an adequate sum for current medical books and periodicals and for the purchase of back publications lost during those recent years when the amount granted was grossly inadequate, thus depreciating the completeness and usefulness of the Library's collection; and an additional sufficient sum annually, for as many years as may be required, in order to make for the greatest possible completeness of the collection and its *Catalogue;* and

BE IT FURTHER RESOLVED, That a sum be appropriated annually to defray the cost of printing regularly each year not less than one volume of the *Index-catalogue,* and

BE IT FURTHER RESOLVED, That a copy of these resolutions be spread upon the minutes of the annual meeting of this Association and sent to the President of the United States, the presiding officer of both houses of Congress, the Secretary of War, the Surgeon-General of the Army, and to the national, state, and other medical periodicals with a request for publication, and to the members of this Association, urging the organization of which they are a part and all other medical associations and institutions to adopt similar resolutions to be sent to their local members of Congress requesting their support of these measures.

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## A Sanguinary Conflict

"Read Your Own Blood Pressure, 10c," was the large sign in front of a device at Coney Island, which has become the storm center of a legal battle. The State Department of Education has asked the Supreme Court to order this and other machines of the kind out of existence on the ground that their operation violates the State Medical Practice

Act. Taking a blood pressure is argued to be a diagnosis of a physical condition, and should not be done except by a physician. The maker of the machines has countered by filing an injunction to prevent interference with his business, and the matter will be fought out in the courts.

On August 12 an operator of one of the machines was arrested on a charge of practicing medicine without a license, and will soon be brought to trial. Any comment here on his guilt or innocence of this offense before the verdict would be in contempt of court, and the next issue of this department might have to be written in the calaboose, so nothing had better be said, perhaps, on that point.

It would be easy to magnify the danger of this blood-pressure device out of all true proportion. Probably nobody with arteriosclerosis is going to burst a blood-vessel when he sees the pointer climb to some high figure on the dial. At the same time we all know that such a casual sidewalk reading is more likely to be wrong than right. The poor dupe who pays his dime may easily be so fidgety that he will show a higher pressure than he normally has. Every doctor knows the excitable type of patient who has to be calmed down and put at his ease before taking the reading, or it will be too high. A leading Boston internist is quoted as saying that he takes three rapid readings in succession in all cases and accepts the lowest systolic and diastolic as the fairest.

The Coney Island device came up in a conversation at the New York Academy of Medicine a few days ago and a well-known physician said it reminded him of an experience related by Heywood Broun, the columnist. It seems that Broun was having a physical examination, and noticed a slight lift of the doctor's eyebrow as he took his blood-pressure. "What's wrong, doctor?" "Oh, nothing." "Why did you lift your eyebrow?" "Well, your blood-pressure is just a little low, but not enough to bother about."

Nevertheless, it did worry him, and a few days later he decided to have another doctor go over him. Again, as he was taking the blood-pressure, the physician's eyebrow arched a trifle. "What's wrong, doctor?" "Oh, nothing." "Why did you lift your eyebrow?" "Well, your blood-pressure is just a little high, but not enough to bother about." The worry had done it. The fact is, of course, that the arterial tension is so fickle an affair that a device like the one at Coney is worse than useless. To take a test after chuting the chutes, bumping the bumps, riding the merry-go-round, and filing up with hot-dogs and peanuts is like counting the pulse after a foot-race. But to get all steamed up over the imaginary perils of the machine is equally too feverish. If some folks are scared into consulting a doctor, they may get a real examination and advice that will do them good. Too drastic action may be like firing a cannon at a flea.

To the above comments, taken from the *New York State Journal of Medicine* for September, 1936, one of the most reliable of the manufacturers of sphygmomanometers adds:

We are vigorously opposed to this misuse of medico-scientific instruments, having gone on record with the American Medical Association to this effect a year ago. Moreover, we have refused to fill large orders for Baumanometers to be used for such purposes.

This evil practice should be stopped and we would appreciate your cooperation in reporting to us any instance that comes to your attention—especially where some definite harm has resulted to a patient.

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### Osteomyelitis of Frontal Bone: Notes on Three Cases

H. P. Mosher, Boston (*Journal A. M. A.*, Sept. 19, 1936), reports three cases, two of which had a fatal outcome. He says that he is convinced even more strongly than he was in his report of three years ago that the edema of the skin of the forehead is a rough guide to the extent of the bone and periosteal infection. If there is actual bone necrosis the bone is infected without necrosis for an inch to an inch and a half beyond the necrotic area. Bone necrosis does not occur until seven to ten days after the pitting edema appears, and the x-ray is not positive until necrosis appears. Examination of the bone specimen removed in two of the cases just reported showed that the infection spreads along the inner surface of the bone, as well as by the diploic veins. When the infection spreads by way of a diploic vein it may localize at a point far from the original

source of infection. When it does so localize, the pus tends to work both inward and outward, giving either a subperiosteal abscess or an extradural abscess, or both, with a destruction of the bone between the two. When a case has lasted two or three weeks, the operator should expect to find one or both of these conditions. The histologic examination of the author's specimens shows in addition that the infection may spread by way of an inner layer of new bone which is formed between the skull and the dura. The small veins which run in the new bone are often infected and there are numerous hemorrhagic clots which also are infected. Further, the infection spreads by way of the fibrous tissue which covers the new bone and which binds the inner surface of the skull to the dura. The operator who is doing his first operation on osteomyelitis of the skull should expect extradural abscesses as a matter of course. In fact, he should expect more than this; he should be on the lookout for a subdural abscess or a brain abscess. The brain abscess, if present, is usually found later or comes later as a complication, but it is always round the corner, and should be watched for even at the first operation. The more he sees of osteomyelitis of the frontal bone, the more he feels that the whole face of the frontal bone should be removed as a routine from the hairline to the eyebrow. Preferably, it should be removed in one piece. However, if the patient is in poor condition and there is an area of necrosis, it is justifiable to work from the necrotic area outward, removing the bone for an inch to an inch and a half in all directions from the necrotic area. He believes further that both frontal sinuses should be opened, and the anterior and posterior walls of each sinus removed. He feels strongly that the lateral limit of the bone flap on each side should be at least the outer angle of each frontal sinus or, better, the outer angular process of the frontal bone on each side. The objection to this extensive removal is the deformity. It has been proved that fully 90 per cent of this can be corrected by modern plastic surgery. Therefore the surgeon should not allow his hand to be halted by the question of deformity. If he does he will lose most of his cases of osteomyelitis of the skull.

October, 1936.

## STATEMENT OF THE OWNERSHIP, MANAGEMENT, CIRCULATION, ETC.,

REQUIRED BY THE ACT OF CONGRESS OF AUG. 24, 1912
Of the Delaware State Medical Journal, Published Monthly at Wilmington, Delaware, for October 1st, 1936

STATE OF DELAWARE } ss.
COUNTY OF NEW CASTLE }

Before me, a Notary Public in and for the State and County aforesaid, personally appeared M. A. Tarumianz, M. D., who having been duly sworn according to law, deposes and says that he is the Business Manager and Associate Editor of the Delaware State Medical Journal, and that the following is, to the best of his knowledge and belief a true statement of the ownership, management (and if a daily paper, the circulation), etc., of the aforesaid publication for the date shown in the above caption, required by the Act of August 24, 1912, embodied in section 411, Postal Laws and Regulations, printed on the reverse of this form, to wit:

1. That the names and addresses of the publisher, editor, managing editor, and business managers are:

Name of— Post Office Address—

Publisher, Medical Society of Delaware, Wilmington, Del.

Editor, W. Edwin Bird, M. D., Du Pont Bldg., Wilmington, Del.

Associate Managing Editors, M. A. Tarumianz, M. D., Farnhurst, Del., and Dr. W. H. Speer, 917 Washington St., Wilmington, Del.

Business Manager, M. A. Tarumianz, M. D., Farnhurst, Del.

2. That the owner is: (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding one per cent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a firm, company, or other unincorporated concern, its name and address, as well as those of each individual member, must be given.)

The Medical Society of Delaware.

3. That the known bondholders, mortgagees, and other security holders owning or holding 1 per cent or more of total amount of bonds, mortgages, or other securities are: (If there are none, so state.) None.

4. That the two paragraphs next above, giving the names of the owners, stockholders, and security holders, if any, contain not only the list of stockholders and security holders as they appear upon the books of the company but also, in cases where stockholder or security holder appears upon the books of the company as trustee or in any other fiduciary relation, the name of the person or corporation for whom such trustee is acting, is given; also that the said two paragraphs contain statements embracing affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner; and this affiant has no reason to believe that any other person, association, or corporation has any interest direct or indirect in the said stock, bonds, or other securities than as so stated by him.

M. A. TARUMIANZ, M. D.

Sworn to and subscribed before me this 1st day of October, 1936.

(Seal) WILLIAM BLACK,
Notary Public.

(My Commission expires July 26, 1938)


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